

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@drl.state.wi.us
Website: <http://www.drl.state.wi.us>

APPLICATION INFORMATION FORM

ATTENTION

IMPORTANT INFORMATION PLEASE READ

Enclosed is the application packet you recently requested from the Wisconsin Department of Regulation and Licensing.

To avoid any unnecessary errors, take a moment to review the entire application packet before you begin to complete your application.

We will mail you a check sheet within 10-15 working days after receipt of your application in this office. The check sheet will include an identification number that allows you to check the status of your application by calling the **Interactive Voice Response System, (608) 261-7925**. The Interactive Voice Response System will inform you of any requirements not met. You may also check the status of your application on our web-site: <http://www.drl.state.wi.us>. Look under "Applicant Services."

It is your obligation as an applicant to see that the items listed as "Is Required" are forwarded to the Department of Regulation and Licensing. The Department will not contact other agencies or jurisdictions for information/documents to complete your application. We will update check sheets within 3-5 working days of receipt of documents. An application is not considered complete until we receive all the required documents and fees.

Once your application is complete, check the department's web-site: <http://www.drl.state.wi.us>. Look under "Business/Professional License Lookup" for your official credential number and grant date.

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MEDICAL EXAMINING BOARD

APPLICATION FOR CERTIFICATION TO PRACTICE RESPIRATORY CARE

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

☐ Your name and address are available to the public.

☐ Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

PLEASE TYPE OR PRINT IN INK

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth ____ month ____ day ____ year	Daytime Telephone Number (____) _____ - _____
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Ethnic/gender status information is optional. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? ____ Yes ____ No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

The respiratory care certification expires on 10/31 of the (even or odd)-numbered year. It may be renewed for a two year period at that time.

School Name: _____

School Address: _____
(City) (State)

Date Diploma Granted: _____
month/day/year

Degree: _____

Specialty: _____

BOARD OFFICE USE ONLY

Temporary Permit Requested: ____ Yes ____ No

APPLICATION FEES Please check applicable blank: (Make check payable to Department of Regulation and Licensing and attach to application).

____ \$ 53.00 Initial Credential Fee
____ \$ 57.00 State Law Exam
\$ 110.00 Total fee attached*

____ **TEMPORARY CERTIFICATE ISSUED PRIOR TO A PERMANENT CERTIFICATE** (Only applicable for those candidates scheduled to take the NBRC exam or awaiting results.)

\$ 10.00 Is required in addition to the above fee (*non-refundable*)

***ORAL EXAMINATION FEE: \$266.00** If you should be selected for an oral examination, the additional oral examination fee will be required prior to being scheduled for the exam.

For Receipting Use Only

Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Fee(s) attached to this application.

Letters from all State Boards where licensed
(includes active and inactive licenses).

Copy of professional diploma and
translation if necessary.

Wisconsin Statutes and Rules Examination
Booklet and Answer Sheet.

Certificate of Professional Education
(Form #1792).

Verification of certification from the National
Board for Respiratory Care (Form #1793).

Copies of malpractice suit(s).

IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.

PRACTICE: Account for all activities and practice from date of graduation to the present time. Must include professional and nonprofessional activities. ALL time and dates must be accounted for.

	<u>LOCATION</u>	<u>DATES (from - to)</u>	<u># OF HOURS</u>	<u>JOB TITLE &</u>
	Employer Name/City, State/Country	mo/yr	<u>PER WEEK</u>	<u>DUTIES</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

I AM CREDENTIALIAED IN THE FOLLOWING STATES (UNLIMITED):

By Written Exam: _____

By Endorsement/Reciprocity: _____

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN CREDENTIALIAED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN MEDICAL EXAMINING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, CREDENTIAL NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR CERTIFICATION.

PLEASE CHECK ONE FOR TEMPORARY CERTIFICATE:

_____ I plan to take the next National Certifying Examination on _____
month/day/year

_____ I have taken and passed the National Certifying Examination.

Wisconsin Department of Regulation & Licensing

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary)

	<u>YES</u>	<u>NO</u>
1. Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever failed to pass any state board examination, national board examination, or NBRC examination? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/>	<input type="checkbox"/>
5. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	<input type="checkbox"/>	<input type="checkbox"/>

Wisconsin Department of Regulation & Licensing

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice respiratory care" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned respiratory care judgments and to learn and keep abreast of respiratory care developments; and
2. The ability to communicate those judgments and respiratory care information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform respiratory care tasks such as examination and treatment procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years**.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 12. Do you have a medical condition which in any way impairs or limits your ability to practice respiratory care with reasonable skill and safety? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does your use of chemical substance(s) in any way impair or limit your ability to practice respiratory care with reasonable skill and safety? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you currently engaged in the illegal use of controlled dangerous substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

Wisconsin Department of Regulation & Licensing

AFFIDAVIT OF APPLICANT (Sign and date in the presence of a notary)

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Hearing and Speech Examining Board or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

Signature of Applicant

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20____, by _____
(Applicant name)

Signature of Notary Public

S E A L

Date Commission Expires

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.¹ A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

First Name Middle Initial Last Name

Profession

Date of Birth _____
 month day year

- -

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,² to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,³ and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.⁴

¹ Section 440.03 (11m), Wis. Stats.

² Sections 49.22, and 440.13, Wis. Stats.

³ Section 440.12, Wis. Stats.

⁴ Health Insurance Portability and Accountability Act (HIPAA) of 1996

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MEDICAL EXAMINING BOARD

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Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

☐ Your name and address are available to the public.

PLEASE TYPE OR PRINT IN INK

Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)
-----------	------------	----	-------------------------

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth ____ month ____ day ____ year	Daytime Telephone Number (____) _____ - _____
--	--

Ethnic/gender status
information is optional.

Sex: ☐ M
☐ F

Ethnic: ☐ White, not of Hispanic origin
☐ Black, not of Hispanic origin
☐ Hispanic

☐ American Indian or Alaskan
☐ Asian or Pacific Islander
☐ Other

Have you ever held a license/credential in the state of Wisconsin? ____ Yes ____ No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

School Name: _____

School Address: _____
(City) (State)

Date Diploma Granted: _____
month/day/year

Degree: _____

Specialty: _____

BOARD OFFICE USE ONLY

Temporary Permit Requested: ____ Yes ____ No

APPLICATION FEES Please check applicable blank: (Make check payable to Department of Regulation and Licensing and attach to application).

____ \$ 53.00 Initial Credential Fee
____ \$ 57.00 State Law Exam
____ \$ 110.00 Total fee attached*

____ **TEMPORARY CERTIFICATE ISSUED PRIOR TO A PERMANENT CERTIFICATE** (Only applicable for those candidates scheduled to take the NBRC exam or awaiting results.)

\$ 10.00 Is required in addition to the above fee (*non-refundable*)

***ORAL EXAMINATION FEE: \$266.00** If you should be selected for an oral examination, the additional oral examination fee will be required prior to being scheduled for the exam.

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APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Fee(s) attached to this application.

Letters from all State Boards where licensed
(includes active and inactive licenses).

Copy of professional diploma and
translation if necessary.

Wisconsin Statutes and Rules Examination
Booklet and Answer Sheet.

Certificate of Professional Education
(Form #1792).

Verification of certification from the National
Board for Respiratory Care (Form #1793).

Copies of malpractice suit(s).

IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE,
DIVORCE DECREE, ETC.

PRACTICE: Account for all activities and practice from date of graduation to the present time. Must include professional and
nonprofessional activities. ALL time and dates must be accounted for.

	<u>LOCATION</u>	<u>DATES (from - to)</u>	<u># OF HOURS</u>	<u>JOB TITLE &</u>
	Employer Name/City, State/Country	mo/yr	<u>PER WEEK</u>	<u>DUTIES</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

I AM CREDENTIALIAED IN THE FOLLOWING STATES (UNLIMITED):

By Written Exam: _____

By Endorsement/Reciprocity: _____

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN CREDENTIALIAED
SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN MEDICAL EXAMINING BOARD. THE LETTERS
MUST INDICATE YOUR DATE OF BIRTH, CREDENTIAL NUMBER, DATE OF ISSUANCE, AND A STATEMENT
REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR
APPLICATION FOR CERTIFICATION.

PLEASE CHECK ONE FOR TEMPORARY CERTIFICATE:

_____ I plan to take the next National Certifying Examination on _____
month/day/year

_____ I have taken and passed the National Certifying Examination.

Wisconsin Department of Regulation & Licensing

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary)

	<u>YES</u>	<u>NO</u>
1. Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever failed to pass any state board examination, national board examination, or NBRC examination? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/>	<input type="checkbox"/>
5. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	<input type="checkbox"/>	<input type="checkbox"/>

Wisconsin Department of Regulation & Licensing

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice respiratory care" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned respiratory care judgments and to learn and keep abreast of respiratory care developments; and
2. The ability to communicate those judgments and respiratory care information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform respiratory care tasks such as examination and treatment procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years**.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 12. Do you have a medical condition which in any way impairs or limits your ability to practice respiratory care with reasonable skill and safety? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does your use of chemical substance(s) in any way impair or limit your ability to practice respiratory care with reasonable skill and safety? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you currently engaged in the illegal use of controlled dangerous substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

Wisconsin Department of Regulation & Licensing

AFFIDAVIT OF APPLICANT (Sign and date in the presence of a notary)

I state that I am the person referred to on this application and that all the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Examining Board of Social Workers, Marriage and Family Therapists, and Professional Counselors or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

Signature of Applicant

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20____, by _____
(Applicant name)

Signature of Notary Public

S E A L

Date Commission Expires

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.¹ A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

First Name Middle Initial Last Name

Profession

Date of Birth

month

day

year

- -

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,² to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,³ and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.⁴

¹ Section 440.03 (11m), Wis. Stats.

² Sections 49.22, and 440.13, Wis. Stats.

³ Section 440.12, Wis. Stats.

⁴ Health Insurance Portability and Accountability Act (HIPAA) of 1996

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DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

BUREAU OF HEALTH PROFESSIONS

IMPORTANT INFORMATION

Applicants, recruiters and institutions and others involved in the placement of individuals who seek to be credentialed in the state of Wisconsin should understand that the credentialing process **may take anywhere from 30 to 60 days**, and that credentialing is not guaranteed to any applicant. Some factors that determine the length of time it may take to process an application depends on the length of time the applicant has been in practice, the total number of jurisdictions the applicant has been credentialed in and the length of time it takes for supporting documents to be received in the board office and reviewed.

The application consists of an all-inclusive packet with instructions and information on all applicable requirements. We attempt to process applications in a timely fashion. We cannot issue a credential until all the required documents have been received and reviewed in the board office. It is the Department's legislative mandate to provide consumer protection for Wisconsin residents.

The Bureau and the Board have been prevailed upon to waive requirements to expedite the process, only to discover legitimate grounds to deny a credential. This can present a serious problem for the applicant, recruiter or institutions if the applicant has relocated, purchased property, or made other commitments prior to the issuance of a Wisconsin credential. **We urge you not to make these moves until you know that your credential has been issued.**

Please "plan ahead" as we cannot speed up the credentialing process nor waive supporting documents even in emergency situations.

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MEDICAL EXAMINING BOARD

RESPIRATORY CARE PRACTITIONER CERTIFICATION INFORMATION

All applicants shall pass the national board for respiratory care CRTT examination as well as an open book examination on Wisconsin Statutes and Administrative Code. Applicants **may** be required to complete an oral examination if he/she:

1. has a medical condition which in any way impairs or limits the applicant's ability to practice respiratory care with reasonable skill and safety;
2. uses chemical substances so as to impair in any way the applicant's ability to practice respiratory care with reasonable skill and safety;
3. have been diagnosed as suffering from pedophilia, exhibitionism or voyeurism;
4. has within the past 2 years engaged in the illegal use of controlled dangerous substances;
5. has been subject to adverse formal action during the course of respiratory care education, postgraduate training, hospital practice, or other respiratory care employment;
6. has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction;
7. has been convicted of a crime the circumstances of which substantially relate to the practice of respiratory care;
8. has not practiced respiratory care for more than 1200 hours during the last 3 years prior to application, unless the applicant has been graduated from a school of respiratory care within that period;
9. has been graduated from a respiratory care school not approved by the board.

An applicant who meets any of the above criteria 1-9 shall be reviewed by the Respiratory Care Practitioner Council to determine whether an applicant is required to complete an oral examination. If the applicant review panel is not able to reach a unanimous agreement on whether an applicant is eligible for certification without completing an oral examination, the application shall be referred to the Medical Examining Board for a final determination.

All examinations shall be conducted in the English language. Where both written and oral examinations are required, they shall be scored separately and the applicant must achieve a passing grade on both examinations to qualify for a license.

An applicant who fails to receive a passing score on an examination may reapply by payment of the fee specified in sec. 440.05(3)(n)7, Stats. If an applicant fails an examination 3 times, the applicant may not retake that state board examination unless the applicant submits proof of having completed further professional training or education as the board may prescribe. An applicant for an oral examination may reapply twice at not less than 4 month intervals.

Wisconsin Department of Regulation & Licensing

If you are selected to appear for an oral examination, you will be advised of the date upon completion of your application.

TEMPORARY CERTIFICATE

1. An applicant for certification may apply to the board for a temporary certificate to practice respiratory care if the applicant:
 - a) has submitted to the board the application and documents required under sec. MED 20.03 Wis. Admin. Code, and remits fee specified;
 - b) is a graduate of an approved school and is scheduled to take the National Certification Examination for Respiratory Care or has taken the National Certification Examination for Respiratory Care and is awaiting results; or
 - c) **IS NOT REQUIRED** to take an oral examination.
2. Practice during the period of the temporary certificate shall be in consultation, at least monthly, with a respiratory care practitioner or a physician who shall at least once a month endorse the activities of the person holding the temporary certificate.
3. A temporary certificate will expire 90 days after the date of issuance or upon notification of failure of CRTT examination whichever is sooner by sec. MED 20.04(1), Wis. Admin. Code.
4. The application and required documents for regular certification and the application for temporary certification prior to regular certification will be reviewed by two members of the council to determine eligibility. The board, acting through the council, may issue a temporary certificate prior to regular certification as a respiratory care practitioner to an applicant who meets the requirements of MED 20.05(1), Wis. Admin. Code.

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: <http://www.drl.state.wi.us>

MEDICAL EXAMINING BOARD

TEMPORARY CERTIFICATE REQUEST FOR RESPIRATORY CARE PRACTITIONER

NAME OF APPLICANT: (Please print) _____

Please check one:

_____ I have taken the National Certification Examination for Respiratory Care and am awaiting results.

_____ I am scheduled to take the next available National Certification Examination for Respiratory Care and wish to begin practicing prior to that time.

AFFIDAVIT OF SUPERVISING RESPIRATORY CARE PRACTITIONER OR PHYSICIAN

I wish to request that a temporary certificate to practice respiratory care in the State of Wisconsin be issued to _____ . I am aware that this temporary certificate will expire 90 days after the date of issuance or upon notification of failure of CRTT examination whichever is sooner by sec. MED 20.04(1), Wis. Admin. Code.

Signature and Title

Agency/Department

Print Name and Certificate Number

Street Address

() _____
Phone Number

City and State

Zip Code

Date

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MEDICAL EXAMINING BOARD

RESPIRATORY CARE PRACTITIONER CERTIFICATE OF PROFESSIONAL EDUCATION

THIS FORM MUST BE COMPLETED BY YOUR RESPIRATORY CARE SCHOOL
AND RETURNED TO THE MEDICAL EXAMINING BOARD

APPLICANT - Please complete this section.

NAME (First, Middle, Maiden, Last)

Social Security Number*

____ - ____ - ____

ADDRESS (City, State, Zip)

Date of Graduation

____ / ____ / ____

CERTIFYING SCHOOL - Please complete this section.

NAME OF INSTITUTION

LOCATION OF INSTITUTION

DEGREE AWARDED

MAJOR

DATE DIPLOMA GRANTED**

Signature of Dean or Department Head

SCHOOL SEAL

Date

* For use in the school locating your records.

** **DO NOT COMPLETE THIS FORM UNTIL THE INDIVIDUAL NAMED ABOVE HAS ACTUALLY GRADUATED.** Anticipated dates of graduation will not be accepted.

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MEDICAL EXAMINING BOARD

REQUEST FOR VERIFICATION OF CERTIFICATION

RESPIRATORY CARE PRACTITIONER

FEES:

Current NBRC members Fee: \$ 3.00
Non-current NBRC members Fee: \$ 15.00

Make check payable to "The National Board for Respiratory Care"

APPLICANT: PLEASE COMPLETE THIS FORM AND ATTACH APPROPRIATE FEE. FORWARD TO THE NATIONAL BOARD FOR RESPIRATORY CARE INC AT THIS ADDRESS:

The National Board for Respiratory Care, Inc.
8310 Nieman Road
Lenexa, Kansas 66214
(913) 599-4200

The **State of Wisconsin** requests a verification of certification of examination concerning the following individual:

NAME

SOCIAL SECURITY NUMBER*

ADDRESS

DAYTIME PHONE NUMBER

CITY, STATE AND ZIP

DATE OF BIRTH

NAME ON CERTIFICATION EXAMINATION
RECORDS IF DIFFERENT FROM ABOVE

MONTH/YEAR OF EXAMINATION

APPLICANTS SIGNATURE

(DATE)

ATTENTION: NATIONAL BOARD FOR RESPIRATORY CARE, INC.

Please mail verification of certification to the Wisconsin Medical Examining Board at the following address:

Department of Regulation & Licensing
Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

***For use by NBRC in locating your records.**

Wisconsin Department of Regulation & Licensing

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Madison, WI 53708-8935

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MEDICAL EXAMINING BOARD

PRACTICE OF RESPIRATORY CARE

LAST NAME: _____ FIRST NAME: _____ MI: _____
(Please Print)

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Enter the percentages of time you have engaged in practice, taught or directed respiratory care in one or more of the categories listed below during the last three years.

NUMBERS 1 – 7 MUST EQUAL 100%

Categories and percentages of practice of respiratory care:

Percentage

- | | |
|---|-------|
| 1. Aerosolize Medication | _____ |
| 2. Oxygen Therapy | _____ |
| 3. Cardio-Pulmonary Diagnostics (e.g. ABG, PFT, ECG) | _____ |
| 4. Non-invasive Cardio-Pulmonary monitoring (e.g. Apnea, Oximetry, Capnography) | _____ |
| 5. Bronchial Hygiene Therapy (e.g. CPT, IPPB, Incentive Spirometry) | _____ |
| 6. Cardiology, Special Procedures (e.g. Cath Lab, Stress Testing) | _____ |
| 7. Ventilator Care/Airway Management | _____ |

TOTAL 100%

Name, address, and telephone number of individual who may be contacted to verify the above:

Name: _____ Date: _____
(Please Print)

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (____) _____

Applicant's Signature

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CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a \$6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: _____

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip) _____

Mail To Address (if different) _____

Date of Birth ____ month ____ day ____ year	Social Security Number ____-____-____ <small>Information helps us identify your record, but is voluntary. It is not available to the public.</small>
--	--

Ethnic/gender information is required to check criminal information records. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: _____
2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.

<u>OFFENSE</u>	<u>DATE</u>	<u>CITY/STATE</u>
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Attach additional sheet(s) if necessary.

Wisconsin Department of Regulation & Licensing

3. Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program? YES NO MO/YR COMPLETED
☐ ☐ _____
Did you successfully complete the program? ☐ ☐ _____
Please attach the certificate of completion/discharge summary.

- (Check all that apply)
4. Have you ever been sentenced to: YES NO MO/YR COMPLETED
☐ Probation ☐ ☐ _____
☐ Parole ☐ ☐ _____
☐ Ordered to pay restitution ☐ ☐ _____
Did you successfully complete one of the above as ordered by the court? ☐ ☐ _____

If you are currently on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are pending. Submit a copy of the police report/criminal complaint for each of the following pending charges.

<u>PENDING CHARGE</u>	<u>DATE OF ARREST</u>	<u>LOCATION OF ARREST (city/state)</u>
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Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

Signature _____	Date _____
-----------------	------------

Signed and sworn before me this _____ day of _____, 20 _____.

Signature of Notary Public _____	Date _____
----------------------------------	------------

My commission (is permanent) _____ expires _____.

SEAL

Wisconsin Department of Regulation & Licensing

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NOTICES

TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.^a An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

PROCEDURES ON APPLICATION DENIAL

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at <http://www.legis.state.wi.us/rsb/code/rl/rl.html> and may also be obtained from the department.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at <http://www.drl.state.wi.us/> under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

AMERICANS WITH DISABILITIES ACT

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Communications and examinations: Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

#1988 (Rev. 11/19/02) ss. 15.04 (1) (m), 19.35, Stats.

^a Section RL 4.06 of the Wisconsin Administrative Code

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APPLICATION PACKET ADDENDUM (INTERNET)

Respiratory Care

For the application packet that you have just downloaded, there are additional materials needed.

Please complete this form and fax it to the number listed above. Once the form is returned we will mail the additional items to the address you have provided. If you prefer, you can mail this form directly to the Department of Regulation and Licensing, P.O. Box 8935, Madison, WI 53708.

Please indicate on this form if you have downloaded the Wisconsin Statutes and Code Book for this profession. ☐ Yes ☐ No

PLEASE PRINT OR TYPE

Full Name

Daytime Phone Number

Street Address

PO Box

City, State, Zip

Thank you.

#2612 (4/03)